Quality Measures Workgroup
Draft Transcript
June 3, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Policy Committee's Quality Measures Workgroup. This is a two-hour Federal Advisory call, and there will be opportunity at the end of the call for the public to make comment.

Let me do a quick roll call. David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Neil Calman? Eva Powell? Marc Overhage? Carol Diamond?

Carol Diamond – Markle Foundation – Managing Director Healthcare Program
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Peter Basch? Bob Kocher? Jacob Reider?

Jacob Reider – Allscripts – Chief Medical Informatics Officer
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Karen Kmetik? She may be joining late. Jesse Singer? Timothy Ferris?

Timothy Ferris – Massachusetts General – Medical Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Laura Petersen?

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Gary Senate? Paul Wallace? Joachim Roski?

Joachim Roski – Engelberg Center for Health Care Reform – Research Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Helen Burstin? David Kendrick? Patrick Gordon? Sarah Scholle? Russ Branzell? Tripp Bradd?

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Charles Kennedy? Norma Lang? Jon White? Patrice Holtz?

Patrice Holtz
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Robert Mayer from SAMHSA? Ahmed Calvo? Gene Nelson? Tom Tsang?

Tom Tsang – ONC – Medical Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
And Lanre?

Lanre Akintujoye – ONC
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anybody off? Okay, with that I'll turn it over to Dr. Lansky.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Judy. Good morning, everybody. We have quite a bit of work to do today, and some hard work at that. The staff ... I want to thank, especially Tom, Lanre, and Pam for getting us organized for this. I'm sorry the material's come late, but I think we'll be able to absorb it as we go.

We're getting to the phase of this process that gets into some heavy lifting, where we actually have to start identifying the sets of measures, which we'll be populating the menu and core going forward into the stage two proposed rule, and I know we've talked a lot about some of the approaches we might take to that. I think our primary job today, looking forward to next week's Policy Committee meeting, is to see if we can come to an agreement about how to structure the measure set in terms of perhaps an alternate core and menu. And in particular, as we've had a couple of hearings recently that involve more of the thinking from the specialist community and their interest in making sure they feel like they're represented in the meaningful use program, to talk about how do we capture some of the measures which are primarily specific to a particular area of practice in our structure reporting quality measures. So we actually, coincidentally have a case study of that today with the behavioral health measures that are attached to the e-mails we got, which obviously primarily comes out of one specialty area, or several specialty areas, actually, and we should talk a little bit about how to capture them in our process. But that provides a test case for what we have to deal with across a variety of other specialties as well.

So what we thought we'd do today, by way of agenda, is to see if we can come to an agreement about the structure of presenting measures to the user community in terms of the core and menu, and also take some time and talk through the roster of methodology issues that have been surfaced and discussed in a couple of previous meetings, and then thirdly talk about the behavioral health questions.

Before we go further into the substance of this, and I think there's a small slide deck that illustrates some of the options on the structure of the menu, let me see if Tom has any other needs, things he wants to get out of us today.

Tom Tsang – ONC – Medical Director
No. I just wanted to acknowledge your leadership and, David, your wisdom in all of this, so, thanks a lot.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, so I'll be tested. All right, so hopefully you all have a copy of the slides, ... them online, and you see the first slide gives us an illustration of a bull's-eye, with a proposal that has a combination, as we said last night, of a core measure set, and we'll talk in a minute about what's in that core, and then the five primary domains that we in the Tiger Teams have been working on for quite a while now. The proposed decision point slide that comes next suggests an approach, which is to maintain a core, to take what used to be the alternate core and put it into the main core so there's just one bigger core now, but it's going to be essentially three required and then you can alternate in some others. This would be a longer, I hate to use the word "menu," but a set of options within the core from which you can choose. Therefore, the core would get bigger. We would have the core, the old alternate core, and some additional measures that would be in the core, and then the other five domains would be the menu, and we would ask providers to choose some number of measures from the core and some number of measures from each domain.

Alternatively, and ... that last bullet point, we could say you don't have to get all five domains if you feel they are not well populated. Perhaps you could ask providers to make sure they address at least three or some other number of domains with some number of measures per domain. So it's all open for creative discussion today. We have a few illustrations, which will help you wrap your heads around how this might appear once it goes public, in a programmatic sense.

Just to remind you of the domain definitions, we've got a short summary on slide four. I think what I'll do, by the way, is kind of walk through this whole structure and then we can come back and critique it and discuss where we want to go. The domain definition on slide four, again, is kind of a reminder on slide five that domains were picked to map to the National Quality Strategy that HHS has published, and a number of other HHS programs are trying to make sure they can cross-walk through ... priorities .... And then, here again under the proposed model this is just a little more refined version of what we saw on the previous slide, keep the core, add additional measures to it, keep a menu, add additional measures into the menu, put it into five bucket areas, have providers – now this proposal, this straw man here is to have providers pick five measures from the expanded core, also end up with a total of at least five measures from the menu, but one per domain. So this presumes we're able to create menus that have enough measures of relevance to every qualifying specialty that they can find themselves with at least one measure in each of the five target domains, as well as from the core. That was on slide six.

The next several slides just provide us several illustrations of how this might play out. These are quick and dirty, but I appreciate Lanre's effort to take each of these and begin to illustrate them for us. The first pair of slides gives a primary care physician, hypothetical Dr. James. Slide seven is just the list of hypothesized core measures for primary care, actually, for everybody. And so among the primary care physicians I look at this list of core measures on slide seven and say the first, second, third, and whatever the ... one and the closing referral loop one, where those diamonds are, would be the five that I pick to report for my core requirement.

On the next slide you'll see Dr. James is looking across the different menus and in the, whatever that color is, pinkish color of the columns you see where Dr. James has identified a measure of relevance to his or her practice in each of the five target areas. So you can imagine there being, if we rotated this picture a little bit, a menu of menu items for primary care that might be rather long in each of the five areas, there might be a number of measures in patient and family engagement, etc. In this case, Dr. James chose to report the diabetic retinopathy measure, communication measure, as a way of satisfying the patient and family engagement criterion.

Let me pause there and let's just kind of catch our breath and see if just the content of what's been presented so far makes sense to people before we get into debating whether it seems correct. Any questions about core, menu and then how in this example a primary care doctor might –

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

This is a great illustration, I think, that puts it, in the following slides it will help non-primary care specialties get engaged with this.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
David, echo thanks. It was so helpful to see some examples. One quick question, and I missed some of the earlier slides so sorry if I'm redundant, so for something such as a process measure that's tightly linked to an outcome, would that come under clinical appropriateness efficiency?

David Lansky – Pacific Business Group on Health – President & CEO
You're opening Pandora's box, Karen. This is a discussion we will come to, of how the groupings should be done and where some of the measures go, so let's hold that thought. I think it's a fairly complex topic.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
All right, thanks.

David Lansky – Pacific Business Group on Health – President & CEO
Other reactions to the general structure we have in mind here before we get into some of these specifics? Okay, so we can just go through and look at the next couple of pairings of this, deepen our familiarity with the model. So here's the dermatology, and Dr. Ramirez is a dermatologist and has done the same kind of assessment and chosen four measures down at the bottom. Now, whether or not Dr. Ramirez is providing care that would be relevant to the other measures and why Dr. Ramirez didn't find a fifth measure, I don't know if Lanre has a comment on that, but you can certainly imagine situations where people in a specialty may have trouble finding themselves in the core. And part of our challenge would be to make sure the core is rich enough to satisfy everybody ....

Lanre Akintujoye – ONC
David, maybe I can make a comment on this. We took extreme cases and this is an extreme case where we've heard some comments from specialties such as dermatology or pathology or anesthesia, where it's not going to be, I think, dermatology will probably not find, if they don't measure blood pressure, if they don't do tobacco cessation, which some dermatologists do, I think we're just depicting a typical scenario where maybe it's going to be a little bit more process driven in terms of the core measures that are shaded, and potentially there may be one or two where they're going to have to put a zero denominator. So we're picturing the extreme case here.

David Lansky – Pacific Business Group on Health – President & CEO
That's good. I think it's a good way to stress the model ....

Neil Calman – Institute for Family Health – President & Cofounder
What do you mean by there's zero denominator, which one would they pick?

Tom Tsang – ONC – Medical Director
We haven't really discussed the details of this, but in the current models, Neil, in order for them to go on to alternate core they have to put zero denominators for all three of the cores in the current situation. And if they can't find any measures at all between the core, alternate core, and even the menu, they have to attest that none of them are applicable. So I think that they would have to attest that the other six within the core are not applicable and not within SOAP and they would have a zero denominator. So they would have to say not one patient is relevant in terms of blood pressure measurement.

M
And to carry that further, Tom, if the dermatologist was a pediatric dermatologist the drugs in the elderly would not even be one of those that he'd choose.

Tom Tsang – ONC – Medical Director

Yes, that's true, yes.

David Lansky – Pacific Business Group on Health – President & CEO
Neil, do you have a thought about that?

Neil Calman – Institute for Family Health – President & Cofounder
I guess it's that part that puzzles me. It's like you have to basically say, you can't just say that it's not generally relevant in my practice. You basically have to say that there's not a single patient who this is relevant for in order to attest that you couldn't qualify to do that –

Tom Tsang – ONC – Medical Director
Yes, I would agree with that, Neil. I would articulate it in that way.

David Lansky – Pacific Business Group on Health – President & CEO
It sounds like someone else had a comment.

Jacob Reider – Allscripts – Chief Medical Informatics Officer
I just was going to ask you if it's time to debate yet. Or are we doing that in a couple of minutes? I know we're doing an overview first. It just was a process question.

David Lansky – Pacific Business Group on Health – President & CEO
Okay, let's just hold another minute and go through ... case, a cardiology case. The next pair of slides has... dermatology ..., we have the menu set for the dermatologist and here you see a somewhat different type of measure that that provider has chosen, including a patient outcome measure on the first one as a patient engagement, so presumably they have some way of capturing patient reported data, and you have all the rest of those here. They only seemed able to satisfy four of the criteria. Whatever the menu was for population and public health they didn't incline themselves there. So this is a good illustration that in the real world we may find people more or less able to find their practice in the measurement set. Conversely, our challenge would be to make sure that the measurement sets are rich enough to address most of the quality objectives at most of the specialties.

We can look again at the surgeon one, just scanning ahead, Dr. Wu found him or herself in five core measures and then in the menu set was able to find at least one in each of the five categories. Now, as you see a number of the menu sets that the surgeons found themselves on fortunately were perioperative and hospital service related so the menu set apparently for the surgeons was rich enough that they could find themselves in it pretty well. And the last case was the cardiologists, and they were able, again, to find themselves in both the core and the menu.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
The issue is, if we take Dr. Wu the surgeon, from the behavioral health issue the issue of alcohol for surgeons and for cardiologists is a very important construct, particularly for anesthesia and the ... surgery workup, but it's missing, so this is one of the concerns that we have. Some things that play a critical role in the assessment should probably be considered part of the core measures. Alcohol is a very ubiquitous phenomenon.

David Lansky – Pacific Business Group on Health – President & CEO
So, when we come back and talk about the composition of the core, and I understand your recommendation, let's see how people feel about the criteria, or the structure we want to take to the core. Obviously, some of those measures, like alcohol screening, may appear in a menu set and that wouldn't necessarily mean that it gets addressed by a wide cross-section of providers, unless it appears in lots of the specialty menus, so we'll come back to that. Given this overall framework, this could go all the way back to the structure as a whole and now that you've seen it play out a little bit –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
David, can I ask –

David Lansky – Pacific Business Group on Health – President & CEO
... people want to react to it. Yes, go ahead.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'd just ask a question on your cardiologist slide. Is there a point being made here on why the cardiologist would avoid the drugs to be avoided in the elderly in closing the referral loop. Perhaps given the latter it's more important because would there be a notion of, or is that for discussion, that we should apply the closing of the referral loop to all specialists?

David Lansky – Pacific Business Group on Health – President & CEO
This is like the alcohol question, I think, Paul. This is a proposal on the table today for us to debate, I think, but right now unlike the previous stage one model where we had essentially a requirement that everyone do the same core measures, here in this proposal there's a menu of core measures and therefore clearly a lot of, in this example, who knows how many measures we would have in our ultimate core, but in this sample, where there are ten or so measures, not everybody reports all of the important things that are on here. I think we have a philosophical question, are we trying to simply validate that people are able to provide some important cross-cutting measures in their own EHR-enabled practice, or are we trying to drive attention to certain important clinical areas that we want to make as commonly required as possible in the interest of quality improvement. So are we really focused on the IT adoption or are we focused on driving quality in a broad brushed way. The more we have menus and the more we have flexibility to the individual providers, the less uniformity we'll see in adoption and reporting rates. So how do people feel about that? Do they want to see a small but required core, or a broad ... core?

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
I have to agree with you on the heterogeneity. If it's too diverse then it will be harder for us to monitor at least some critical variables. So we do want to ... core.

Neil Calman – Institute for Family Health – President & Cofounder
I would make a case for the fact that there's a core of core and that there's certain things that we want everybody to do, and closing the referral loop would be one. I don't know if there are any providers that don't prescribe any medications, maybe there are, but medication reconciliation. It seems to me that patient education for diagnosis in encounter is universal. No matter what you're doing there's patient education involved in every encounter. I guess, maybe to make it easier there are certain things that we really could call out. Those would be the three that jump out at me. There's always education. You always want for specialists, for them to close the referral loop, and I think medication reconciliation, you can argue, is really relevant no matter what you're doing if you're prescribing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I wonder if two of those three are already incorporated into the functionality objectives and we might have a better way of measuring the adherence to meeting the satisfaction of the functionality objectives, so we have a medication reconciliation and sort of a patient education. Closing the referral loop is certainly one that's come up consistently every time we have either primary care or specialty care hearings, and I wonder if we can paint closing referral loop, from the primary care point of view that's the same thing as giving the reason for a consult, that this could literally be a part of core core, which is applicable to everybody, and just have two different ways of interpreting and referring and consulting.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, you make a really good point that we should keep our eye on our prize of clinical outcome measures where we can, and good clinical process measures and then the other measures, like patient experience, that we also value highly. So we want to be having as many as possible quality measures here and not functional criteria that we're measuring whether they're being executed, so keeping that distinction a little bit in mind. These are ones that Neil called out are a little bit on the fence between functional versus actual quality metric.

The proposal that I think even was ... Neil's comment of having a core core. Another way that we could think about that is going back to the pink columns in the menu, one could have a small core, which is

virtually required, much like stage one, maybe constructed differently, as Neil suggested. But then have a sixth column in the menu, a sixth menu, if you like, which, for lack of a better word we can call clinical process measures. And I'm now getting back to Karen's comment from a while ago, in which some of the things we're looking at here that are in the tentative core slide get moved to a specialty specific menu of clinical process measures that might be germane to a dermatologist or a primary care doctor or a pathologist, but are not going to be universally applicable across the whole core. It adds complexity because it adds a sixth little menu, but it makes the core really a core instead of itself being a menu. So given that's another option on the table, let's continue your assessment of which way you think you'd like to go forward.

Jacob Reider – Allscripts – Chief Medical Informatics Officer
I'd like to add maybe another thought to this and there are two perspectives. One is the EHR vendor perspective, just food for thought as we think this through, there are EHR vendors that make very narrowly focused products. Especially if you think about modularity, there are vendors that make products that are appropriate for a very narrow population, say, a wound care specialist or a physiatrist. What I've heard from those vendors is that stage one was very challenging because they needed to create functionality in their products that enabled the capture and reporting of core measures that were completely irrelevant to their provider population. So this added cost to vendor development, it slowed their development of innovative components of their solutions and so on.

I guess with my vendor hat on I want to just bring this up that as we think about core we run the risk of mandating functionality in products that is irrelevant and wasteful. So in that light I'd like to think about maybe a different way of looking at core and alternate core and menu. This will be a little bit redundant and is something I said in the past, is that I would support getting rid of all three of those and creating just a big menu, and then within that menu there's still a recommended core, so, A) trying to simplify it; and B) giving extra points. So let's say, for example, that there were 20 items that needed to be selected by a given provider, if I'm a primary care physician I might get 2 points for the things that are considered core, so I might do 5 core and then that would be 10 points, and then I would pick 10 others. If I'm a sub-sub-specialist, if I'm a pediatric retinal ophthalmologist or something, I might need to pick more things out of the menu and I wouldn't get the points from the core. So with this hypothesized point scoring system you would enhance the likelihood that people would do the core because they get more points for them, but you wouldn't mandate the core. Then if an EHR vendor were to have a product that didn't have anything to do with anything in the core, they wouldn't have to create functionality. It's just food for thought. I'll go back on mute.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Jacob. That's a very helpful perspective. Other comments for or against any of these?

Daniel Green – CMS/HHS – Medical Director
Just to respond to the last commenter's points, one thing I think we need to cognizant of, when an eligible professional decides to purchase an electronic health record they may or may not know at that time which measures that they're going to want to report. Many of the programs are more generic and appeal to many different specialties, whereas, I know there are some obviously that are geared more, let's say, toward ophthalmologists or what have you. But I think it's important that we suggest that the functionality be broad so that folks can report whatever measures they think are most important to them or the core measures that are mandated. The other advantage of core measures, as I'm sure you all know, is if you ever want to compare physicians' performance, at CMS we're looking at value-based purchasing, with the ACO programs and what have you, so it enables, if you have at least a standard set of measures, it enables you to look at the providers and compare them to one another. So I think those are two things to consider.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Dan. Other people? Let's see if people can speak very specifically to which model they would advocate or anything new they want to put on the table so we can try to get to a decision here.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

I like Jacob's idea of weighting specific healthcare priority measures. That really puts the emphasis on the things that are important if they remain in a core like that, that way people would have a tendency behaviorally to choose that anyway, but actually be doing something I think along with what Jacob's alluding to.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks. Other votes? We are coming down to the wire where I think next week we have to really represent hopefully a shared view of how to proceed, so I'd appreciate people wrestling with their good angels and deciding how best to handle this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One of the principles we've been espousing is parsimony. I wonder if another one, and it did come up in the meaningful use Workgroup, is simplicity versus complexity. So while it's attractive to start weighting priorities I'm wondering if it just adds some complexity that just makes it more confusing to interpret and then confusing to implement.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director
I would agree with Paul on that. While from a public health perspective it may be useful to go through different weighting exercises, but we then would have to decide well, what are the other different ways and how would they be determined. Would they be determined based on impact on morbidity and mortality or some other criteria, and as we start out I would also advocate for simple and straightforward and that may lead to the weighting of one, or equal weighting, I should say.

Neil Calman – Institute for Family Health – President & Cofounder
I agree. Simplicity is very important here.

David Lansky – Pacific Business Group on Health – President & CEO
Those of you who are voting for simplicity, or at least for non-weighting as a methodology, where do you come down on the size of the core menu and the types of things that make it – we went through this a year, year and a half ago. We wrestled and we ended up with a very small core and even that has proved moderately controversial. We could repeat the exercise and probably come out at about the same place. The idea of creating a choice list, a menu within the core, partly addresses the difficulty of having such a small core, ... that, but at the obvious trade-offs we talked about.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
David, I'm just going to maybe state the obvious. We got here because we felt like we wanted core, and as Dan Green said, there's great value in having a core. But if we have a large number of providers for whom those don't apply, we're asking them to do ... and tell us it doesn't apply, and that seems cumbersome. So what's proposed here is to expand the core so that we have fewer providers saying nothing in the core applies to me, and that seems like a good general direction. We probably still won't get it right and there's a balance between how big you make the core menu, but it seems that this notion is moving us to avoid the issue that we're trying to avoid, so we've got a core that does not apply to so many people, causes confusion, and causes EHR vendor problems. Jacob, I guess my question back to you would be, if we have this expanded core so there's some flexibility would that be better received by the vendor community?

Jacob Reider – Allscripts – Chief Medical Informatics Officer
Thank you, Karen, you were reading my mind. The problem is it wouldn't. It actually increases the burden on the vendor community because it increases the mandated functionality. So the functional components of clinical quality measures was this secret functional requirement for EHR vendors, so when we looked at the certification requirements they actually didn't say core clinical quality measures here. And so as we expand this, and again think about wound care EHR, that may or may not need to capture certain things, so as we expand the core to make it flexible to physicians, so as a physician I like that idea but as an EHR vendor I get concerned. And as a representative here of vendors I know that when we have our bimonthly meeting this afternoon I'm going to hear about this, so I do want to make sure that

that voice comes out. As this expands it is going to be, we should understand that each one of these core measures is a functional requirement for EHR vendors.

David Lansky – Pacific Business Group on Health – President & CEO
Let me see if I can test the proposal I made earlier and make it a little more specific and get yea or nay reactions to it. Imagine we stay with the stage one core, which the vendors have already addressed and the community already understands, for better or worse, but add the sixth column I suggested on clinical process measures, which is essentially core but it's a core for a specialty. And so we can differentiate the pathologist from the plastic surgeon from the primary care doctor, does that address the vendor and the specialist view of the world? Because they can then look at that sixth column and say, okay, here are the oncology measures, or the plastic surgery measures, whatever it is, that are core to my specialty, so to speak, in the clinical process world and probably even recommended by my specialty society and maybe are already in PQRI or wherever they appear, they're familiar. And the vendors in that space, if it's an oncology EHR, are already probably familiar with some of those requirements. But then the core stays what it was and we maintain that construct and concept for the purposes that Dan and others identified rather than trying to re-tool the core. The complexity we're adding in that scenario is the sixth column, the sixth menu set, which is essentially a specialty process category.

Jacob Reider – Allscripts – Chief Medical Informatics Officer
From a vendor view I think that would address some of the issues, so that the EHRs that are very specialty specific, I agree with you, would likely address those areas that are within their specialty. I think that would address it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How does that limit the number of things that the vendors have to do? Would a specialty EHR vendor be able to choose which measures they'd implement? I'm not sure how that sixth column helps them.

Jacob Reider – Allscripts – Chief Medical Informatics Officer
If we don't expand stage one, the vendor, as David described, has already delivered their stage one functional components whether they wanted to or not. So my example of the wound care EHR, now they would focus on additional, perhaps new core measures that are focused on that specialty, and as David said, maybe those would be defined by that specialty society or a practice domain. And if there's a vendor that wants to focus, and I agree with Dan, as you all know, I work for a vendor that is a very broad vendor so I'm trying to represent the folks who don't have a voice here. Many people will purchase broadly functional EHRs, but some won't, some want best of breed for their narrow functionality in their domain. Did I answer your question, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm not sure. But I don't need to – one comment on just the breadth of information that should be stored in an EHR. We still want to maintain a relatively small number, but is it unreasonable to ask even a wound EHR vendor to have a certain amount, let's say the total set is 60, because it's still important about that patient, the wound care person certainly has to know diagnoses and allergies, etc. There are a lot of things that they need to be able to receive, remember the health exchange, and is that number small enough that it's reasonable to say all vendors, including specialty vendors, need to be able to receive that information so that it becomes part of the record for that specialist.

Jacob Reider – Allscripts – Chief Medical Informatics Officer
Yes, of course.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I understand how it's a specialty, a narrow focus, but I'm not sure that the number of quality measures we end up even in stage three will be that onerous considering it's a total patient care document.

Neil Calman – Institute for Family Health – President & Cofounder
It sounds like what we're saying is they need to have the process capability of capturing that information, but they might not have the capability of reporting it. Is that what we're saying, that the vendors would

save time and money for their clients by not having to develop reporting around the non-relevant measures but they're still going to have to capture all of that information and still have the functionality in their systems? Is that correct?

M
... data, so I agreed with Paul that a complete data set, but there is data that we can receive, so a small vendor making something that's very focused for their domain may not capture that data, Neil. But –

Neil Calman – Institute for Family Health – President & Cofounder
... successful?

M
... blood pressure. They're going to be able to have a place to put all of this information, aren't they? I don't understand. Give me an example.

M
The pediatric ophthalmologist may not have a functional status evaluation that we might see in a geriatrician, and the geriatrician may need to capture that information and a pediatric ophthalmology product wouldn't capture that, wouldn't have any way to capture it. It may store it, because I can get a CCD and represent that in the system in some way, but I don't have a form or a template or a mechanism of capturing that data discreetly and reporting on it.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice
Neil, are you referring back to your core core thing?

Neil Calman – Institute for Family Health – President & Cofounder
No, no, that answered my question. I was just trying to understand where the savings really was in that it seemed like there was a very limited number of things that wouldn't be relevant if you're capturing it in an exchange type of model through a transfer of a CCD and you're going to put it into an EHR in a way that's indexed and can be retrieved, it seemed to me, like I didn't understand where the savings was. But your explaining that the savings is that you don't have to program the part that says where do I put the stuff if I actually asked those questions of the person.

M
And remember that when we can't get a CCD we're not necessarily, because we can talk to the Standards Committee, but we don't really have semantic interoperability to get to the granularity that we need to. So if I catch a CCD, that functional status evaluation or that ... score or something that I capture may not be represented discreetly in my system. It may exist in my system, but I can't store it discreetly and then report on it discreetly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Part of the agreement that we had before was that it's not unreasonable to say that virtually all systems should be able to receive certain data and it's captured in a small number of quality measures. Now, you're saying that today we don't have all the standards defined so that we have semantic interoperability for all quality measures that exist. But could we limit ourselves to the quality measures for which those standards do exist and then that increases over time? Aren't we in a transition where today actually it's pretty hard to get information out reliably and consistently amongst the systems, but hopefully by 2015 shouldn't that particular problem be much better?

M
Well, I think it will be better, but again I'm trying to represent folks who are different from where I live on a day to day basis, but if I can receive that information I still may not represent that in its native reportable form if the scope of my product doesn't see a need to do that. So if I don't ever need to capture depression scores because I'm an anesthesiologist, why would I put it in my system? Does that make sense, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, it does. And that's what Neil was asking. Yes, the first answer is we should be able to receive all these things, all the data that's in these quality measures, but we may not be able to report on them today. I think my only concern is let's not do anything that would limit where we're headed by today's limitations.

M
Yes, I agree. And you all know, I aspire to ... semantic interoperabilities like the next guy, so I don't want to state ... and I do think we should anticipate greater levels of semantic interoperability. I'm just trying to think about where there are going to be puddles that we might step in.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But not stop paving roads because there are puddles around that we ought to ... measure too. We can't pave around the wound EHR and avoid all the benefits of everybody else who needs some certain information and that can benefit patient care.

M
Agreed.

David Lansky – Pacific Business Group on Health – President & CEO
Let me see if I can, given our time today, focus on, I hear so far three options on the table and we should probably see if we have any consensus, or maybe we don't, then we should present the options in some form to the Policy Committee. The first option is what we presented in the slides today, which is the expanded core that essentially picks several from the core as well as the sub-menus. The second option that Jacob sketched was having everything as a menu, but with weighting to guide people toward emphasizing the core. And the third option is the one that I put out, which is keeping the old core but add a sixth category for the clinical measures that are of interest to that specialty and don't naturally fit into the five buckets we've recently identified. Those are three big approaches and maybe someone can put forth a fourth approach –

Tom Tsang – ONC – Medical Director
David, can I ask you about the third option, where you said keep the old core and where would you put the more parsimonious new measures, such as closing the referral loop and drugs to be avoided in the elderly?

David Lansky – Pacific Business Group on Health – President & CEO
Well, I think it depends on whether they either would appear very frequently, so for example the drugs in the elderly might appear in many specialties' clinical process menu, but not in the pediatrics menus, for example, or maybe in some but maybe not in the pathology menu. I think they would go wherever they belong in the proposed six categories. If they're really functional and not clinical quality measures, then we'd come back to Paul's point, make sure they're well represented in the meaningful use functional criteria.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
David, I do see value in your suggestion. It enables us to keep the core. It enables us to begin to really develop other cores, to Dan's point, to enable some comparisons down the road that make sense. I think what we would want to do is make sure we hold firm in terms of the measures in your additional columns having certain attributes, such as covering some of the things we're all saying we're interested in, making sure it's absolutely tightly linked to outcome, etc. But it seems like that does solve some of our dilemmas.

David Lansky – Pacific Business Group on Health – President & CEO
Karen, going back to your very first point when we started the call, I just want to add a clarification in the way that I was looking at it. A fear I have is that the category we've been calling clinical appropriateness and efficiency may become the dumping ground for all the process measures when we don't know where else to put them and it might therefore squeeze out the original concept where that health priority came from. So appropriateness can be watered down to mean any clinical process of generally used and

quality measurement. Originally this was a category meant to be driving toward resource use, affordability of appropriate care decisions and so on. So I like, personally, the idea of keeping that focus on appropriateness and efficiency of resource use and having another place to put the many other process measures that are important to the specialties, but cover a wide variety of process measures.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Yes, I understand that, David, and that makes sense. The other, I guess, advantage of your sixth column is, as you said, it's going to take a while for us to fill out the pink columns for everyone, but it keeps a light on it, but it keeps momentum going and just putting a place for these other important things linked to an outcome hopefully.

David Lansky – Pacific Business Group on Health – President & CEO
Other comments about the several choices we have that are in front of us?

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
I agree with the issue of what was just stated. I think the important thing for us to keep in mind is that even though vendors are working in a static situation, ... quality measures should be future oriented and we will be expecting changes in not only the primary care but the specialty approach to medicine. So while those things have not been resolved, we want enough elasticity in the process to allow this to evolve. We don't want people trapped in the static environment and then resistant because they don't want to reinvest in additional software or additional architecture in the future.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is there still a notion in all of your options of a required for everybody core?

David Lansky – Pacific Business Group on Health – President & CEO
Of the three options I just summarized, I think only the one I put out still has the old-fashioned core.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, the required core.

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the only addition, because meaningful use stage two is focused on care coordination as one of its high priorities, would it be acceptable to propose that the "referral loop," and it has both sides, both the reason for referral as well as the timing of the reply, be a core core, a required core?

David Lansky – Pacific Business Group on Health – President & CEO
In principle, I think, sure. The other way to handle it would be to make it essentially universal in the care coordination column, in the pink column, so that virtually every specialty sees that as one of their items available in the –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So it still wouldn't be required?

David Lansky – Pacific Business Group on Health – President & CEO
Right, so that's the drawback. So if you think it should be required, I don't have any strong feeling about the old core is the only core we should consider. Maybe there are new adds to it.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice
David, as laid out, I agree with your proposal.

M

David, one more question. In the third option then would you have the ability to choose measures in the menu set as, so we have six domains, would you choose one or two measures from a selection of measures?

David Lansky – Pacific Business Group on Health – President & CEO
What do you mean by a selection of measures?

M
So if you have six domains in the menu set and they're compartmentalized as patient safety or care coordination and there's three or four measures in each domain, are we asking the providers to choose one measure out of the three, or would you –

David Lansky – Pacific Business Group on Health – President & CEO
I think in my picture, I don't know what the right number is, but yes in concept you would be required to do at least one or whatever number per domain.

M
So to Paul's point then, if he wants closing the referral loop to be a core core then there's a possibility if you put it in the menu then it may not be selected.

David Lansky – Pacific Business Group on Health – President & CEO
Right, that's right. So I think anything we think is virtually universal –

M
Right, so I'm just going back to the point of if you really want anything that you want everyone to do we're going to have to put it in the core core. I just want to make that clear.

David Lansky – Pacific Business Group on Health – President & CEO
And anything that anyone identifies that's emerging as potential core core we should get it in the queue so we can talk about it. Any other votes in favor of the original model on today's slides, or the weighting the measures model that Jacob outlined, or the third model that I outlined as gradually being amended?

Neil Calman – Institute for Family Health – President & Cofounder
I would vote for the third model and definitely vote to include the closing the referral loop as a core core.

Daniel Green – CMS/HHS – Medical Director
I would vote for the third model as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And Paul would vote for third with the closing the loop as core core.

David Lansky – Pacific Business Group on Health – President & CEO
Any strong dissenters from going down that path, at least in concept, and with some details to work out?

Jacob Reider – Allscripts – Chief Medical Informatics Officer
I'm supportive but guarded about additions for reasons we've gone through.

David Lansky – Pacific Business Group on Health – President & CEO
Okay. We have ....

M
....

Timothy Ferris – Massachusetts General – Medical Director
... to see if we couldn't make some effort, and maybe Karen could help us with this, to quantify the number of docs who would still be left out in this approach.

David Lansky – Pacific Business Group on Health – President & CEO
Tim, what do you mean by left out? You wouldn't be able to meet the core?

Timothy Ferris – Massachusetts General – Medical Director
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
Yes. Yes, I would actually empirically, Tom, I don't know if you have any data yet or a feeling from observation, or Karen, whether the early registrants around meaningful use have indicated that the core is working for them or not working for them, or any sense empirically of how widely it's touching people.

Tom Tsang – ONC – Medical Director
It's still a little bit early. The data's coming in, but we don't have anything conclusive.

Timothy Ferris – Massachusetts General – Medical Director
I can tell you what it is from my institution.

David Lansky – Pacific Business Group on Health – President & CEO
What are you seeing, Tim?

Timothy Ferris – Massachusetts General – Medical Director
Fifty percent.

David Lansky – Pacific Business Group on Health – President & CEO
What are the other 50% doing, are they alternate core or just zeroing out?

Timothy Ferris – Massachusetts General – Medical Director
Zeroing out.

David Lansky – Pacific Business Group on Health – President & CEO
Interesting.

M
Fifty percent of the entire health system, Tim, or is 50%, and is that –

Timothy Ferris – Massachusetts General – Medical Director
Clinically active physicians.

M
And the demographics, is that primarily 80% primary care and 20% specialists?

Timothy Ferris – Massachusetts General – Medical Director
The opposite.

M
Eighty percent specialists and twenty percent primary care docs?

Timothy Ferris – Massachusetts General – Medical Director
Yes.

M
Okay.

David Lansky – Pacific Business Group on Health – President & CEO

So that, I would say, gives us some support for re-thinking how people qualify, because, Tim, what does that do to your thinking about the third model, that is keeping the old core? Because we know it's not working for a lot of providers. Does it take you back to the big menu approach or some other hybrid?

Timothy Ferris – Massachusetts General – Medical Director
Maybe I misunderstood what you were proposing as your third model, but I thought that got us to a point where we were going to have more people qualifying?

David Lansky – Pacific Business Group on Health – President & CEO
In my proposal I didn't waive the old core. I kept it. And if it's not working for a high proportion of providers, we ... that too.

Tom Tsang – ONC – Medical Director
David, is there a real distinction between your proposal one and proposal three? If we're expanding the core elements to be a little bit more inclusive, to have more parsimonious measures, are you just eliminating the option to select? So, for example, if you have seven core measures you have to do seven, as opposed to seven out of ten or five out of ten?

David Lansky – Pacific Business Group on Health – President & CEO
I suppose you could say it that way. I don't know that we'll be able to get to seven given the history of this discussion.

Tom Tsang – ONC – Medical Director
All right. In my mind I don't see a real distinction between one and three and expanded core versus, you know.

David Lansky – Pacific Business Group on Health – President & CEO
... taking Paul's suggestion and slowly growing the core core with closing the loop or whatever else we can add to it, then yes it does become a little bit more robust. But I'm just skeptical that we've had good luck in expanding the core in the last round of discussions.

W
To me, David, the third option, it just gives some clarity. In essence, could we say that there's a core core, the nation's core, and then there are the specialty cores?

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

W
You have to do a core, either the nation's core or the ... core. Tim, does that address your colleagues' concerns?

Timothy Ferris – Massachusetts General – Medical Director
I think it does if it's an either/or.

David Lansky – Pacific Business Group on Health – President & CEO
Well, the fear is you'd get people, very few of them, doing the core core at some point. That might be a loss from a policy point of view, to Dan's comment, although I do like the idea of knowing that for plastic surgeons or ophthalmologists we're going to begin to get, as Dan said earlier, at least a small core for that specialty of widely adopted measures. That's a win, I think, from a policy point of view.

Timothy Ferris – Massachusetts General – Medical Director
I would agree with that, David.

David Lansky – Pacific Business Group on Health – President & CEO

But I do worry that if I'm a plastic surgeon and I can basically ignore the core core and just go to my specialty core, then that's kind of a loss for the broad public health goals we've had in the core, like blood pressure control and so on.

M
Well, like medication reconciliation, if it's not tied to a discharge, from a hospital discharge, we'd all agree that doctors should be updating their patients' medication list every visit, so that's kind of a broad thing that everybody can report on conceivably.

Timothy Ferris – Massachusetts General – Medical Director
Yes, and, David, I think there's another frame here in terms of the broad policy consideration. It occurs to me that the plastic surgeon or whoever treating a given patient who's not going to be providing data on the core because it doesn't apply to them, that patient is also presumably seeing a primary care doctor who will be reporting on that because that's core to what they do. And so from a patient, therefore a public health perspective, the core is not being lost, it's being reported on through some of the doctors who are taking care of that patient, but not all of them. But that doesn't mean from the patient frame that we're not collecting the data on that patient. It's just that it's not coming through their plastic surgeon.

David Lansky – Pacific Business Group on Health – President & CEO
That raises an extension of the proposal, which may be too radical for us, which is to say there is no core. But there is that sixth column which is the place where the core appears so that for 70% of specialists, including the primary care, family care specialists, what we call the core, that appears in their menus so that there's no universal national core. There's just a predominant core that appears for most specialists, which is the same items we've been talking about during stage one.

M
We need to be careful about making assumptions about the delivery system. We're assuming that specialists only get their referrals from primary care and that ... independent presentations. So if you get an independent presentation or a person who's infrequently engaged in primary care, then the specialist is the point of best contact for some of this basic information. So I like the notion of a core because it does say that there's a network of practitioners that we're dealing with, so unless you've got an HMO or an accountable care organization which requires a primary contact where that information is being shared. We should not be assuming that all specialists will receive information or transmit information to a primary care practitioner.

David Lansky – Pacific Business Group on Health – President & CEO
Good point. I think for today we've got a rough consensus. There are some loose ends to think about, but let's take this version, version three. We still have a core, this loose possibility of moving the core into a menu, but for now I think we should try to move on to some other topics if we have enough agreement. Now I'm going to see if Tom and Lanre and Pam feel like they've got enough out of this discussion to get to the next level of refinement.

Lanre Akintujoye – ONC
Hi, David. Would you just mind summarizing exactly what the third model is in terms of what the core is and what the menu looks like?

David Lansky – Pacific Business Group on Health – President & CEO
As I hear it, the third model is to retain the stage one core, potentially add one or more items, including the first proposal, closing the referral loop to the old core. So the core would then have four core measures, to keep the five columns that we've been talking about that are domain specific, and adding a sixth one, to be named something like clinical process measure or something.

Lanre Akintujoye – ONC
And what are we doing with the alternate core?

David Lansky – Pacific Business Group on Health – President & CEO

I think we need a solution that lets people find their alternate measures in the sixth column. I would ... in the spirit of what Tim was suggesting.

Lanre Akintujoye – ONC
So if you zero out in three of the four core you have to make up to three from the specialty clinical process column. That's what you're saying?

David Lansky – Pacific Business Group on Health – President & CEO
We haven't talked this through. I'm making it up on the fly to get people's reactions to it.

Patrice Holtz
Tom, one of the things that we did get a lot of comment on for the core and the alternate core at CMS was that the alternate core measures that are there have a population stratification that are more conducive to peds. So it's not just the topic area that we have to look at, but it's also the age range because some docs aren't going to see adults and vice versa.

David Lansky – Pacific Business Group on Health – President & CEO
So what's your recommendation, Patrice?

Patrice Holtz
I would recommend, because a lot of people liked the alternate core measures and were able to respond to them, like the pediatricians, that we actually keep the alternate in there.

David Lansky – Pacific Business Group on Health – President & CEO
Keep it as an alternate or put it with the core?

Patrice Holtz
Put it with the core.

David Lansky – Pacific Business Group on Health – President & CEO
Okay, I just want to be clear. Okay.

Patrice Holtz
Yes. Dan, did you have thoughts on that?

Daniel Green – CMS/HHS – Medical Director
No, sorry.

David Lansky – Pacific Business Group on Health – President & CEO
Okay, well there's obviously plenty of layers of complexity still to be sorted out and I don't think today we can get into the next question that Patrice is raising about the population applicability. One scenario there is to say that in effect the pediatric core in the sixth column, but maybe there's a broader reason to keep it in the core core, but let's not try to resolve that one on the call today and let's go to some other topics. Lanre, was my summary enough to get you where you need to be?

Lanre Akintujoye – ONC
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
Okay. Well, thank you all, very enlightening and instructive. We covered some more ground. We'll see what kind of reaction we get. And we'll try to put this together into a format that we can vet with everybody before the Policy Committee call next week.

Tom Tsang – ONC – Medical Director
I think what we'll do, ONC staff will try and put together the thoughts and summarize this on paper over the weekend, and we'll share it with folks hopefully by Monday morning.

Lanre Akintujoye – ONC
I think the goal is to put all of these recommendations and draft them up into a letter that we will then submit to the committee, and then the committee can look at it and provide their revisions by that same day.

David Lansky – Pacific Business Group on Health – President & CEO
That will be great. And then we can discuss them with, we have some time on the agenda with the Policy Committee next Wednesday and we can present all of this to them and get some feedback from their perspective as well. The next topic we have on our agenda today was the methodology issues that have been bubbling for quite a while. Pam sent out a one pager today which summarizes five issues that we are proposing to encourage the Policy Committee and the Standards Committee to take up to advance our ability to do new quality measures and more robust and broad quality measures than some of the ones we've been used to. I don't know if Tom or Pam or Lanre wants to walk through this note and get any reaction from people and see if they're comfortable with taking it forward? Tom, do you want to do that, or someone else? Are you there?

Tom Tsang – ONC – Medical Director
Yes, I'm sorry. I was on mute. You're talking about the methodologic issues, right?

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Tom Tsang – ONC – Medical Director
Helen – I'm sorry I'm trying to –

David Lansky – Pacific Business Group on Health – President & CEO
Yes, I haven't heard if Helen's on with us today.

Tom Tsang – ONC – Medical Director
Helen led the call and she's been leading the Tiger Team on methodologic issues over the last few months. I think there are some very clear cut infrastructural and standard issues that we need to, or the workgroup has to recommend to the HIT Policy Committee as well as the HIT Standards Committee to stand up in order for some of these innovative, novel measures to be implemented. I'm trying to find the document here.

David Lansky – Pacific Business Group on Health – President & CEO
I can start in while you're looking, if that would be helpful.

Tom Tsang – ONC – Medical Director
I got it. So the first one, a vehicle to capture patient reported data is needed. So there are a lot of discussions about standards that are needed in terms of self-reported data, especially from mobile devices, capturing information from fingerstick machines and glucometers and etc. and how do we capture that information there. The other thing is a vehicle to capture, for example, if we have functional status surveys, the VR-36 and VR-12 and ..., and we're doing that through a patient portal, what's the mechanism of capturing that information and having that information incorporated into the EHR as well as C.32. So I think there are some technical issues that the committee has to contend with. The other issue is a CDA type of standard and transport mechanism for some of these self-reported data. So that's the first issue that we've all, I think the committee and the workgroup has identified.

The second one is policies that can guide reasonable measures of quality for comparison of data points over time. I think this issue is first related to how data can be calculated locally across time frames as well as from multiple sources, again, the issue of transport mechanism is going to be an issue. The issue of when we have delta measures are we looking at progression, if we're looking at HbA1c are we looking at progress or are we looking at attaining the thresholds. So I think there are concerns about what's the, I

guess the purpose of the delta measures. And I don't know if Karen or Dan or any others who were part of this discussion on delta measures could elaborate on this or help with this point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Tom, I'm not answering your question, but as far as delta measures for meaningful use wouldn't we only be doing reporting and we wouldn't actually have a threshold performance requirement?

Tom Tsang – ONC – Medical Director
I would say you're right, Paul. I'm just bringing out the concerns of the members of the workgroup.

Lanre Akintujoye – ONC
I think the point on the delta measures was that there are some measures where there's longitudinal focus and so you might be trying to track change over time, and the methodologic issue is how do you decide which specific data points you choose to compare to and how do we frame that within an EHR system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point.

Tom Tsang – ONC – Medical Director
So we don't have a lot of answers, we're just pointing out some of the difficulties and challenges in using delta measures here. The third point on promoting capacity and scalability of EHRs to be in step with increasing complexity of quality measures. I think this one is related to the notion that if we're creating measures that have a computational algorithm overlaid on top of a measure, such as using a Framingham Risk Score to assess LDL control, it needs multiple data points from the EHR. So how would you establish this computational algorithm as part of the core function of the EHR, what's the architecture to support the data management and analytic platform. And it's the same thing with any other measure that's going to be using a risk prediction model.

Then the fourth point is about coding for problem lists. I think there's a lot of discussion about such standards as SNOMED being a little bit more granular, however, most EHRs and most providers are using ICD-9, and then the issue of working towards ICD-10, how is that going to affect the problem list. The other thing is there's a huge amount of data signaling, for example, the blood pressure hypertension measure, it uses ICD-9 codes, diagnose hypertension, whereas, many patients are under-diagnosed and if we use measures that look at numerical values of blood pressure we would probably get an increased denominator and have a better impact. So I think there's a lot of issues of the standards limited to the use of ICD-9, and I guess this has to do with the content of the measure as well. Then lastly, there was a discussion on attribution in terms of provider, if measures are going to be provider based or team based or as measures look at across various ... how do we attribute the content to which provider or which team of providers. David?

David Lansky – Pacific Business Group on Health – President & CEO
I think where we're trying to go now is to see if this is a reasonable summary of the key issues that we would want to recommend for further investigation by other groups, and have some general discussion if people support taking this forward to the Policy Committee or not.

Tom Tsang – ONC – Medical Director
Are you talking about just taking the list forward and saying that these are the issues that we want to discuss, right?

David Lansky – Pacific Business Group on Health – President & CEO
I think some of these become requests of the Standards Committee to do the deeper work in the areas that we've identified as gaps.

Sarah Scholle – NCQA – Assistant Vice President, Research

The only comment I have is in terms of the priority of these methodological issues the problem list seems to rise to the top.

Tom Tsang – ONC – Medical Director
Sarah, can you elaborate why and what your thoughts are about this?

Sarah Scholle – NCQA – Assistant Vice President, Research
Well, because some of the other functionalities, like the one about additional capacity and scalability, seems to address measures that are a little further out in the future. And the issue of practically how can we make the measures comparable from one place to another really rests on having comparable denominators, and we're not going to get that unless we have a real strong sense of what's on the problem list.

Neil Calman – Institute for Family Health – President & Cofounder
I would say that the attribution issue is huge and I don't know if the standards are the place to put that. To me that seems like much more of a policy kind of a question to tackle with before somebody's actually sitting down to figure out how that works. But the attribution issue is huge, because it cuts to the core of part of the transformation that we're trying to achieve in the healthcare system now, which is not basically seeing it as a physician only sort of structure. As we promote models of team care I think we have to tackle the fact that the responsibility is not going to be totally physician driven. Even though this incentive program that we're now dealing with is, I think if there's an opportunity to have that discussion and understand how that works.

I also think that, and I mentioned this before, that I think that the definition of attribution also has something to do with the denominators and whether you're looking at refined denominators. So physicians can say, yes, I accept responsibility for this patient because they've been in 14 times in the last year, or you brought in those denominators so that people start to recognize responsibility even for people that haven't returned for care and for people who have touched their system but have been lost to follow up in others. And that those issues get addressed as you brought in the denominators, the ability of the system to capture and maintain relationships with a particular patient becomes a factor, not just measuring how people do with the folks that are already deeply engaged in our delivery system. I think these are really very, very important issues. I just don't know what the appropriate venue is for them to be discussed.

David Kendrick – Greater Tulsa Health Access Network – Principle Investigator
I would endorse that the attribution issue is the number one thing on our metrics in our Beacon community that's holding us up. So that would be great to prioritize that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
While, I like all of these issues and think they're very important and will cause change to happen, I would like to point out the time urgency of the whole coding of problem lists, the ICD-10 versus SNOMED. All of the providers are, right now, going through that transition and they're making decisions about ICD-10 and SNOMED, so I think this could be a very important timely policy question to help give providers some heads up and ....

Timothy Ferris – Massachusetts General – Medical Director
I view the need to make progress on this as in this general area of the patient reported outcomes and the issues that Tom went through. And because of what I see as really sort of treacherous and difficult waters associated with the attribution issues and the denominator issues that prior discussants have mentioned, I view progress. So near term progress as being relatively opportunistic and much simpler in the space of registries when you have an episode of care or in the context of registries where it's pretty clear that there's a before and after and the value of the changes is much better documented in delta measures. So I'm not sure that I'm adding something meaningful to the conversation except to say that our own work here is, because of the headaches associated with the denominators and attributions we're looking to implement these in rather narrow context associated with procedures where we have registries in place. And that gets you around all of those prior issues that the discussants were discussing.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, the registry issue is the one that keeps coming up as a sub-case of the larger set of solutions around data integration platforms, and we haven't really, given the nature of our EHR incentive program, haven't tried to get into it. But I think several of the items on this list lend themselves to a discussion about the other data platforms that are not the EHR itself. So I appreciate where you're going with that, Tim, but ... sort of a bigger scope problem for us to think about.

Timothy Ferris – Massachusetts General – Medical Director
Yes, that's why my caveat that I wasn't sure that it was a helpful comment.

David Lansky – Pacific Business Group on Health – President & CEO
I haven't heard defending that these are all important issues. We haven't tried to prioritize them or hand them off to particular processes to be dealt with. Neil raised the question of whether some of them are really policy issues that we don't want to per se treat as standards problems, like the attribution question.

Tom Tsang – ONC – Medical Director
David, I hear from the group that perhaps the problem list and perhaps the patient reported data platform could, at least from my mind, as a short term issue to tackle they're much more, I guess, pragmatic in terms of dealing with, they could be within the scope of the Standards Committee that we could send off and have them vet this issue with. I mean, they're issues that we need to really deal with, to Sarah's point, these quality measures we really have to make sure that they're implementable and that has to do with, it's critical to make sure that we have the right vocabulary and we have the right code sets. On the issue of the attribution, I honestly don't know where that will sit and perhaps that's something that Paul and others at the Policy Committee can think about.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, I like where you're going, Tom, in kind of stratifying this list into the issues that are Standards Committee oriented and of those which are short term and which are long term. And if we say that the code list of problem list is, and essentially putting a time stamp on each of these and saying how quickly do we need some set of guidance in order to be effective for stage two. So, as Paul suggested, if the problem list problem is a high priority one we can ask the Standards Committee to address that soon and think through that issue. If the sourcing of patient reported data is something we want to address for stage two in order to capture more patient experience and patient engagement measures then that is also an early priority that we can ask for early attention on. Then we could bump the issue of longer-term architecture through computation and the methodology issues around time-oriented measures as less urgent standards related issues that we would want to throw over to the Standards Committee but with less urgency.

Then finally number five, we throw to Paul and basically say this seems like a Policy Committee ... and find another vehicle for that discussion that's really around the policy implications of attribution. So that's my rough parsing of this list given what we've said so far. Any thoughts about that?

Neil Calman – Institute for Family Health – President & Cofounder
I think that's a great model. I agree with it. And I'm going to have to sign off to get on another call.

David Lansky – Pacific Business Group on Health – President & CEO
Okay, thanks. Any other further comments about this methodology list?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It might be a policy question about the whole problem list coding. As you know, the Standards Committee already said ICD-9 or SNOMED, do we have an opinion from a policy point of view, what would suit our quality measure needs more ably?

Tom Tsang – ONC – Medical Director

Paul, Jim Walker and his group, the Clinical Quality Workgroup is actually working with NQF and Floyd on vetting the right code sets in respect to the QDM model. What they're doing is they're analyzing and stressing the QDM with some of the measure concepts that's coming out of this group and working with the vocabulary harmonization process to work on that issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Will they have recommendations coincident with the quality measure recommendation for stage two?

Tom Tsang – ONC – Medical Director
I think they're aiming towards the June 22nd HIT Standards Committee meeting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. I just fear, David, that if it is important to choose one of these two and we miss this time when everybody's already making the decisions we won't have the time again.

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

M
.... I might surprise everyone. From a vendor perspective, I think there would be support for SNOMED ... just to call the question and say come on, let's go. I think there would be support in that and I think it's the right move. And everybody seems like we're dancing around it and afraid to go there, but I will support just going there.

David Lansky – Pacific Business Group on Health – President & CEO
..., Paul, maybe with the Standards Committee there should be some kind of a little caucus or process to evaluate the issues on this one that's both a policy and standards discussion with key people and providing input.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Tom, in the exercise you said that Jim Walker's group is doing one of the eight questions they are addressing, which is the coding system that is more suited for quality measures.

Tom Tsang – ONC – Medical Director
It's specifically relevant to the QDM, yes. And there's actually a meeting on Monday, this coming Monday on the 6th at 2:00 p.m.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This can fundamentally help or hurt our whole effort in measuring these things.

David Lansky – Pacific Business Group on Health – President & CEO
I don't know the answer, Paul. I'm wondering if working with Jim's group and the full Standards Committee there should be a short-term Tiger Team workgroup, something that takes it up and gets some input from vendors, methodologists, measurement people, and gets some input and then comes to the recommendations.

M
I think that would be great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

M
There would be a lot of enthusiasm for that from the vendor community. As folks may know, we worked with Karen Kmetik and with Floyd at NQF on the genesis of what Floyd is working on now, for exactly the reason we're talking about right now –

Tom Tsang – ONC – Medical Director
I'd like to hear from Karen and from Sarah what their thoughts are about this conversion to SNOMED.

David Lansky – Pacific Business Group on Health – President & CEO
Karen may have left. She had a short amount of time.

Tom Tsang – ONC – Medical Director
Okay.

Sarah Scholle – NCQA – Assistant Vice President, Research
This is Sarah. We've mapped to SNOMED.

Ben - NCQA
All of the vocabularies are there and we've created vocabulary lists of code sets in SNOMED, I-9, I-10, CVX, RxNorm, you name it, they're all there. It's a matter of where in the architecture they are, clinical summaries, patient history, problem lists. So, yes, the SNOMED codes are there, they're reviewed appropriate lists in various components in the QDM, but the greater issue is the different vendors mapping to those code sets.

M
Then would you update the old eSpecified measures and as part of the maintenance process recalibrate the logic models using only SNOMED?

Ben - NCQA
Right now our plan is to continue to update the code sets across the board, so all of the code sets. As we receive public comment feedback, as we find issues through implementation, as we've been doing through these ..., we've been receiving a lot of feedback on the proposed code sets. So I think there will be ongoing update for SNOMED, ICD-10 and everything at this point until everyone agrees on only one taxonomy and then we would just focus on that, because it is resource intensive.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But I think that's the policy question we're trying to pose and we're trying to meet this timing, because this is what's going on now, and I think there will be loads of changes again. While they're changing –

Sarah Scholle – NCQA – Assistant Vice President, Research
So the question is, if we move should we focus on SNOMED exclusively?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The right people to make the decisions should get together, as David was proposing this Tiger Team, and say will we have better measures, will we improve our ability to measure outcomes that are important to patients and care if we use one code system or not. And if there is a significant difference, this is the time.

Ben - NCQA
SNOMED offers the greatest specificity because there are the greatest number of SNOMED codes that define the largest number of clinical processes. It's still a system that's not perfect. There are still some things that are not in SNOMED, specific biometric variables, but if there are ways that you can link the SNOMED code processes to specific components in the EMR, aka blood pressure values, then I think that would be a code set I would probably recommend moving forward with.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can I check the corollary to that, or the opposite is do you believe ICD-10 is not sufficient or not adequate to accurately measure the outcomes that we're looking for.

Ben - NCQA

It's absolutely adequate as well, and that's why we're currently maintaining both code sets and developing both code sets concurrently because they also have different purposes. ICD-10 right now is still in the claims system, which is much more informative in the resource use appropriateness realm because it's something that's been in use in arenas already.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, but you may not be asking the same question. We're talking about the diagnoses which helps us determine the denominator and you believe ICD-10 is adequate to do that.

Ben - NCQA
ICD-10 is adequate, but SNOMED is probably better.

Tom Tsang – ONC – Medical Director
Paul, I see where you're going at. But I think the difference is the ICD-10 you may have 400 codes for diabetes, or even specifying a diabetic with nephropathy and proteinuria you would have to find all the different, there's a code for each and every single separate thing. Where I think the logic model just makes more sense in SNOMED, where you can actually build the codes together and there's a building block that's kind of like, I think semantically it makes more sense in SNOMED. But I see where you're going at and I think there needs to be great discussion with, I guess, the measure stewards and the vendors in that discussion as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This goes back to David's suggestion of having a Tiger Team –

Tom Tsang – ONC – Medical Director
Yes, yes. The other thing is that on the flip side, though, it does affect the workflow of providers. If providers are doing referrals and doing preauthorization for medications, there has to be a link to ICD-10. And if only ICD-10 exists in the practice management portion and not within the EHR portion, then when you're doing referrals and preauthorizations for medications, there has to be a mapper that spits out an ICD-10 code.

Sarah Scholle – NCQA – Assistant Vice President, Research
That's a really good point, Tom, I think.

David Lansky – Pacific Business Group on Health – President & CEO
Let's not try to get –

Sarah Scholle – NCQA – Assistant Vice President, Research
Eventually billing systems will talk to them, right?

David Lansky – Pacific Business Group on Health – President & CEO
I don't think today, given our purpose and our time, we can get too much deeper into this. It sounds like the general agreement is it's an important and somewhat complex area. I guess I'm wondering whether you're all comfortable in our letter in recommendations to the Policy Committee for next week on this issue we recommend that they consider forming a Tiger Team, a short-term analytic group to take up all these questions ... from the Standards and Policy Committee and inviting other contributors to the conversation. Is that acceptable to everybody?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. I'll have to drop off, David.

David Lansky – Pacific Business Group on Health – President & CEO
Okay, Paul. ... coming to you.

David Lansky – Pacific Business Group on Health – President & CEO

Given that and the conversation we've had, I think hopefully again we can ask Pam or Lanre to rework this one pager a little bit so it becomes input to the Policy Committee next week and with that we can move on to the behavioral health measures question. You saw in your packet today three versions of proposals around behavioral health measures that we're being encouraged to consider. Now, I'll see if Tom or Wes or someone else might get us oriented to what we need to do with these.

Tom Tsang – ONC – Medical Director
Wes, do you want to take a crack at this?

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Sure. The behavioral health coordinating committee has looked at the whole measure development process and recognizes the importance of having quality measures for behavioral health under consideration. Pam Hyde and Howard Coe sent you, through Farzad, a series of quality measures that we think should be included in the full consideration. Quality measures for behavioral health that has been developed through HRSA, ... and CMS ... for alcohol and substance abuse disorders with patients with bipolar or major depression, ... depression remission at six and twelve months. Follow up care for children prescribed medications for attention deficit hyperactivity disorder, alcohol ... including documentation for ... intervention and follow up plan as appropriate, a depression screening and primary care using a validated instrument including documentation follow up, and then of course suicide risk assessment for use in primary care. We believe that there should be some standard screening questions for substance abuse in primary care, particularly given the concern about the misuse of prescription ... major epidemic CDC has pointed that out. Then trauma, since it's actually a primary care issue standard screening question for trauma for use in primary care, and then the inclusion of behavioral health and post acute long term care providers ... for meeting the proposed ... exchange criteria.

We include an appendix which has these measures in them. We recommended the inclusion of those measures in stage two, ... coordination ... and then we outlined the importance of that. We also give a table and Attachment A of the proposed measures and the status of those measures. We also got a letter from the Office of the National Drug Control Policy, which essentially captures the same issues. There is some interest in the federal government having these things addressed by this committee, and we should make sure we include behavioral health as an integral part of what measures are favored for stage two meaningful use.

David Lansky – Pacific Business Group on Health – President & CEO
That's very good, thanks. So we'll get that as three documents, two of which the letter from Dr. Coe and the letter from ..., both summarized into the four proposed measures that we are encouraged to consider, and then there's a more detailed table, closer to measurement specs kind of a table that we have as an attachment.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Right.

David Lansky – Pacific Business Group on Health – President & CEO
So let me ask, these clearly are something, and maybe you said at the beginning of the call, Wes, some of these would naturally fall into even the core or to a very broad swath of providers where these are of general relevance. Some of them may be judged as not as relevant, and we can either contemplate whether any of these go into the core core, or we could contemplate whether they go into other domains in our potentially six columns, either by specialty or very broadly. Do people, without trying to get into the details today, because we have hundreds of measures that we'll have to take up this question with, any general reactions to how you'd like us to proceed with the proposal of behavioral health measures being included in stage two?

M
David, I just want to add that out of the 8 measures being proposed, 2 of them already have been eSpecified and are part of the 113. So we're talking about 6 additional measures.

David Lansky – Pacific Business Group on Health – President & CEO
The ones that are already specified, do you have a sense of where they would show up in our menus,... contemplating them?

M
Well, if you take the third option and have the sixth clinical process column, it's assumed that these two would go in that bucket, depression, looking at depression remission at six and twelve months and looking at follow up care for children prescribed with ADHD.

David Lansky – Pacific Business Group on Health – President & CEO
Okay. The other items that are on the proposal may or may not, we have to do some analysis, may fit also into the other categories. Is the issue, Tom, whether they've been eSpecified?

Tom Tsang – ONC – Medical Director
They haven't and they'll need to be, and tested and validated as well. I think the proposal was for the workgroup to consider these measures and make a recommendation of where they would sit, should the committee decide to accept these measures.

David Lansky – Pacific Business Group on Health – President & CEO
Leaving aside the issue of the perform tested HIE, which is kind of a different topic for the moment, the ones that would need to be eSpecified, does anyone know if there's work in progress to do that?

Tom Tsang – ONC – Medical Director
No. I think perhaps Wes would have better knowledge, but I think these, if the committee is moving forward with this recommendation then I think folks within HRSA, SAMHSA, and CMS would try to get funding to move forward with the work.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Yes, that's the case. We've already talked to NQF and the issue is we do believe that we have some commitment to move forward with these specifications and that the key issue is getting this committee to recognize the importance of that and allowing us to move forward on that.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice
As a primary care physician I'll tell you that to understand the scope of this it's unknown, even clinicians don't know how many people use illicit drugs, nor ask about it, and the same is true about alcohol. So as far as their priority that people don't know about, I'd have to support these measures. They're rampant in our society, absolutely rampant.

David Lansky – Pacific Business Group on Health – President & CEO
Any other reactions? I think on the merits everyone probably thinks these are important issues that deserve attention. How they fit in with our larger priorities and so on would need some more discussion.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Yes, I think one ... consider, as the previous speaker pointed out, many of these items are rampant and it is typically tied to quality care and the performance of what it is the people are doing can get with hypertension or diabetes without dealing with the issue of medication compliance. As was pointed out, alcohol use is a ubiquitous phenomenon and we have to make and that the problem of alcohol consumption is about 20 million people with alcohol and other substances, but we've got risky behavior where people actually don't comply with their basic primary care problems because of the misuse of substances.

Depression, on the other hand, is also a major phenomenon which interferes with peoples' ability to comply with treatment regimens, preventive strategies, and medication issues. Often people don't think of some of the behavioral health phenomenon as germane until way down the road when they realize they're dealing with a patient who doesn't seem to "understand" the importance of doing the right thing.

When you look at the basis of that it's either substance use or misuse or psychological issues like depression or bipolar affective disorder.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, absolutely.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice
One of the things, particularly the alcohol screening brief intervention we participated in a study with our research network and it was incredible both from just overseeing the whole study, looking at the whole study, but also from a patient to physician perspective how this really made a big difference. I can tell you that most doctors don't really ask about this, and this could even be a core, from my perspective. Again, I speak from a primary care perspective and not from a country wide perspective that some of you guys should hear.

David Lansky – Pacific Business Group on Health – President & CEO
Yes. Let me ask Tom, what action do you think is helpful for this committee to take at this –

Tom Tsang – ONC – Medical Director
As a committee that fully accepts these recommendations as a consideration for stage two and stage three, then I think the next action is when we decide on the proposal for the core core and the menu, we'll just have to figure out where to place most of these measures then. But at least it will give an indication to ONC and to CMS that there's an interest in moving forward to have these as part of the clinical quality measure set and we can move forward with some of the work in supporting in the eSpecification retooling process and the testing process of these measures.

David Lansky – Pacific Business Group on Health – President & CEO
Let me ask the group if everyone's comfortable with at least items one, two and three and the sub-items under number one being included in our list of candidate measures to be populating the measure set, the core and the menu. And I'll come back to item four in a second, but is anybody not comfortable adding these to our list of measures and then we'll take them up in more detail when we get to the specifics?

Timothy Ferris – Massachusetts General – Medical Director
I'm comfortable adding them. I think it would not be difficult to anticipate the pushback on these because the concepts that are being promoted here are not new. So screening for these things in practice, and I'm a primary care doctor, and efforts to introduce systematic screening for all kinds of risk and behavioral issues are decades old and there's a very big literature around the successes. There's also a very big literature around the failures and if one were to summarize them, one might summarize them, or I might summarize them as saying they expand exponentially the work of the person who's doing it, because it's not just the work of collecting the information, it's what you do with the answer. And what you do with the answer is invariably complicated because of the nature of what it is we're talking about. And I know probably everybody on this call knows all that stuff, but it's just that no one said it and I, again, go back to my original statement, I'm for including these. But the pushback is relatively predictable.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
I think that's what the ACA is about, is making sure that we have, this is Westley, that we have a delivery system that has sufficient capacity to do something about it. We at SAMHSA have invested a substantial amount in screening for substance use, both alcohol and illicit drugs, and we've been able to establish strategies to "do something about it." So concern is legitimate, we recognize that. And for the past five years we've been actively invested in marshalling the ability of primary care not just the physicians but the nurses and health educators all in the primary care setting to be able to address the issues so that we don't overtax the system. We create a network of referrals, and we close the loop on addressing the issues. So we want feedback out there because ultimately your effectiveness in terms of the primary effort becomes undermined if we don't deal with it. So we hear what you're saying. We think that as this evolves, particularly as we prepare the special delivery system for 2014, we also need to make sure the primary care delivery system is poised to make things more efficient also.

David Lansky – Pacific Business Group on Health – President & CEO
Hearing general support in concept of at least adding those one, two, three on the list, let's do that. Then on number four, this really goes back a little more to Paul's committee, the larger question of the stage two measures for meaningful use, and we have recalibrated the old HIE measure. And I don't know, Paul, if you have it handy what the, I don't think have it right in front of me, the reworking of all that. Do you have it in your head the reworking of the HIE Exchange criteria, which we got rid of the ... providers. Does anyone on the top of their head have what the current proposal is? Perhaps not. Why don't we take that under advisement and come back to that. It really doesn't belong as much in the quality measures category –

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Okay.

David Lansky – Pacific Business Group on Health – President & CEO
... functional criteria category. We can certainly, Wes, circulate back to you and the others who sent us letters on that particular issue as well as on this one.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Okay, that's fine. I really appreciate your reviewing this, so we'll keep on it.

David Lansky – Pacific Business Group on Health – President & CEO
Good. Well, thanks for bringing it to us. It's very important stuff and I hope we can move the ball in this area with our process. Let me just see if, Tom, are there any other issues we didn't get to today that you want any more input from us on?

Tom Tsang – ONC – Medical Director
No. I think that you complete your task of getting a lot out of this call, so I think we have a few things to do in terms of from a staffing side in getting a document out and trying to capture the initial discussion on the core plus menu options, and then reworking the methodologic document.

David Lansky – Pacific Business Group on Health – President & CEO
Great, well let me thank you and thank all the staff for getting us down the road to where we could have a good conversation and try to come up with the next step in our process. From the committee before we do the public comment any other last thoughts, reactions, advisement to pass along? Thank you to everybody on the workgroup for taking so much time and thoughtful contributions to the discussion. Judy, can we see if there's any public comment?

Judy Sparrow – Office of the National Coordinator – Executive Director
Sure. Operator, can you check and see, please.

Operator
Yes. We do have public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great, thank you. Can you please identify yourself?

W
Mr. Chung, please go ahead.

Henry Chung, M.D. – Montefiore Medical Center
Hi, this is Henry Chung from Montefiore Medical Center. I just wanted to commend the committee for looking at the behavioral health measures and prioritizing them, from what I can tell, appropriately. As someone who is knee deep in transforming our health delivery system and working in the Bronx County of New York, the inclusion of these behavioral health measures are totally key to our success, quite frankly, to managing a high need population. I think that the definitions need to be probably more fully specified from a primary care perspective, but overall I think this is very much on the right track and I just

want to commend the committee for really being quite advanced in taking account of the evidence base and the experience that we've had in the field. This will not be easy to do for any of us, but it's definitely the right direction and I think will provide much better care for the large majority of patients who have both medical and behavioral health needs.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Mr. Chung. Do we have anybody else?

Operator
You have no more comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. Thank you, David Lansky and everyone else.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, everyone. Talk to you soon.

M
Bye.

M
Bye.

Public Comment Received During the Meeting

1. Pathologists generally do not prescribe medications.